

Request for permission for oral testimony at Idaho
Medicaid's P&T Committee meeting on 04-20-2012

Submission # 2

As of April 10, 2012, this request has been:

☐ Approved

☒ Denied

Gennrich, Jane - Medicaid

From: Eide, Tamara J. - Medicaid
Sent: Friday, March 30, 2012 11:36 AM
To: Gennrich, Jane - Medicaid
Subject: FW: Submission for Idaho Medicaid P&T Committee Meeting - April 20, 2012
Attachments: Idaho Medicaid Cover Letter.pdf; IDAHO Medicaid MRC March 2012 Final.pdf; xarelto_PI_Dec 12.pdf

Tami Eide, Pharm.D., BCPS

Medicaid Pharmacy Program Supervisor/Manager
Idaho Department of Health and Welfare
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208-364-1829
800-327-5541 fax

From: Wagner, Judy [OMJUS] [<mailto:JWagner7@its.jnj.com>]
Sent: Friday, March 30, 2012 10:48 AM
To: Eide, Tamara J. - Medicaid
Cc: Litzenberger, Laura [OMJUS]
Subject: Submission for Idaho Medicaid P&T Committee Meeting - April 20, 2012

Dear Dr. Eide,

We are requesting that the P&T Chairman or their designee permit the enclosed new scientific data on **XARELTO®** (**rivaroxaban**) be presented orally by Laura Litzenberger, Janssen Scientific Affairs Liaison at the April 20, 2012 P&T Committee meeting.

Please find attached a cover letter and summary of the new scientific data, including the prescribing information.

Please let me know if you have any questions or need anything additional.

Kind Regards,

Judy Wagner, Pharm.D.
Associate Director, Medical Information CV
Medical Information & Services
Janssen Scientific Affairs, LLC
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908-218-7590
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March 30, 2012

Tami Eide, PharmD
P.O. Box 83720
Boise, ID 83720-0036
US

Dear Dr. Eide:

Thank you for your interest in XARELTO® (rivaroxaban), marketed by Janssen Pharmaceuticals, Inc. Laura Litzenberger has forwarded your specific request to Medical Information and Services. The enclosed information has been supplied to you in response to your unsolicited request and is not intended as an endorsement of any usage not contained in the prescribing information.

Response(s):

- XARELTO - Idaho Medicaid Summary

For complete information, please refer to the enclosed full XARELTO Prescribing Information, including the following sections: **BOXED WARNING(S), INDICATIONS AND USAGE, DOSAGE AND ADMINISTRATION, CONTRAINDICATIONS, WARNINGS AND PRECAUTIONS, and ADVERSE REACTIONS.**

If you have any additional questions, please contact us via:

- Phone: 1-800-JANSSEN (1-800-526-7736) Monday - Friday, 9:00 a.m. - 5:00 p.m.
- Web Site: www.janssenmedinfo.com

To report a possible adverse event or product quality complaint, please call the Customer Communications Center immediately, at 1-800-JANSSEN (1-800-526-7736).

Please contact Laura Litzenberger if you need additional information at (520) 751-4100 or llitzenb@its.jnj.com.

Sincerely,
Judy Wagner

Judy Wagner, BS, PharmD
Manager
Medical Information
Medical Information and Services

Inquiry #: 1-1463256678

Enclosure(s): See page 3 for a list of enclosure(s).

XARELTO® (rivaroxaban)

The following information is provided because of your specific unsolicited request and is not intended as an endorsement of any usage not contained in the Prescribing Information. For complete information, please refer to the enclosed full Prescribing Information, including the following sections: **BOXED WARNING(S), INDICATIONS AND USAGE, DOSAGE AND ADMINISTRATION, CONTRAINDICATIONS, WARNINGS AND PRECAUTIONS, and ADVERSE REACTIONS.**

XARELTO - Idaho Medicaid Summary

Attention Idaho Medicaid Reviewer:

Please find enclosed your XARELTO® Medicaid summary¹ in advance of the Idaho Medicaid meeting on April 20, 2012. This information is provided as a professional courtesy in response to a request forwarded to us by Laura Litzenberger, PharmD, Senior Liaison, Health Economics and Clinical Outcomes Research Field - Janssen Scientific Affairs, LLC - Johnson & Johnson.

As specified by the Idaho Medicaid Pharmacy and Therapeutics (P & T) Committee Public Testimony Guidelines, the information provided represents either of the following:

- New studies released since the last review, excluding placebo studies only
- New product or new indication information not included in the Magellan Therapeutics Class Reviews posted on the P & T Website

XARELTO®:

- NEW STUDIES:

- A subgroup analysis of the **ROCKET AF** (**R**ivaroxaban, **O**nce-daily, oral, direct Factor Xa inhibition **C**ompared with vitamin **K** antagonism for prevention of stroke and **E**mbolism **T**rial in **A**trial **F**ibrillation) trial in patients previous stroke or transient ischemic attack has been summarized (page 1;STUDY 1).
- The **ATLAS ACS TIMI-51** (**A**nti-Xa **T**herapy to **L**ower cardiovascular events in addition to **A**spirin with/without thienopyridine therapy in **S**ubjects with **A**cute **C**oronary **S**yndrome **T**hrombolysis **I**n **M**yocardial **I**nfarction 51) study in adult patients with a recent ACS has been summarized (page 1;STUDY2).
- The Acute Pulmonary Embolism (EINSTEIN-PE) study in patients with acute PE has been summarized (page 2;STUDY 3).

Please refer to the enclosed XARELTO® Full Prescribing Information² for complete prescribing information.

ENCLOSURE(S):

- XARELTO® (rivaroxaban) Tablets Full Prescribing Information. Janssen Pharmaceuticals, Inc; Titusville, NJ: Revised December 2011.
- Xarelto Idaho Medicaid Summary. Revised March 2012.

REFERENCE(S):**XARELTO® (rivaroxaban)****XARELTO - Idaho Medicaid Summary**

1. Xarelto Idaho Medicaid Summary. Revised March 2012.
2. XARELTO® (rivaroxaban) Tablets Full Prescribing Information. Janssen Pharmaceuticals, Inc; Titusville, NJ: Revised December 2011.

XARELTO® (rivaroxaban) Tablets
Idaho Medicaid Summary

STUDY 1 - A subgroup analysis of ROCKET AF (Rivaroxaban, Once-daily, oral, direct Factor Xa inhibition Compared with vitamin K antagonism for prevention of stroke and Embolism Trial in Atrial Fibrillation) comparing rivaroxaban with warfarin in patients with atrial fibrillation and previous stroke or transient ischemic attack (TIA)

- Hankey et al. (2012)¹ conducted a prespecified subgroup analysis of the ROCKET AF study to assess whether the efficacy and safety of rivaroxaban compared with warfarin among patients with previous stroke or TIA was consistent with results among patients without previous stroke or TIA and the entire study population.
 - ROCKET AF was a multinational, randomized, double-blind, double-dummy, event-driven, trial that compared fixed-dose rivaroxaban (20 mg daily or 15 mg daily in patients with creatinine clearance 30-49 ml/min) with adjusted-dose warfarin (titrated to target INR 2.0 – 3.0) to prevent all stroke or systemic embolism in patients with nonvalvular atrial fibrillation.
 - Patients (n=14,264) were randomly assigned to treatment in ROCKET AF. 7468 (52%) had experienced a stroke or TIA before study entry and 6796 (48%) had no previous stroke or TIA. Among all patients with a previous stroke or TIA, 3754 were allocated to receive rivaroxaban and 3714 to receive warfarin.
 - The primary efficacy endpoint was the composite of adjudicated stroke and non-CNS systemic embolism. The principal safety endpoint was a composite of major and non-major clinically relevant bleeding events.
 - The number of events per 100 person-years for the primary endpoint in patients treated with rivaroxaban compared with warfarin was consistent among patients with previous stroke or TIA (2.79% rivaroxaban versus 2.96% warfarin; HR 0.94; 95% CI 0.77–1.16) and those without (1.44% rivaroxaban versus 1.88% warfarin; HR 0.77; 95% CI 0.58–1.01; p-value for interaction =0.23).
 - The number of major and non-major clinically relevant bleeding events per 100 person-years in patients treated with rivaroxaban compared with warfarin was consistent among patients with previous stroke or TIA (13.31% rivaroxaban versus 13.87% warfarin; HR 0.96; 95% CI 0.87–1.07) and those without (16.69% rivaroxaban versus 15.19% warfarin; HR 1.10, 95% CI 0.99–1.21; p-value for interaction =0.08).
 - The treatment effects of rivaroxaban and warfarin in patients with previous stroke or TIA were consistent with those in patients without previous stroke or TIA and with the overall trial population.

STUDY 2 - Pivotal study in adult patients with a recent acute coronary syndrome (ACS) (sNDA submitted to FDA on December 29, 2011)

- ATLAS ACS TIMI-51² (Anti-Xa Therapy to Lower cardiovascular events in addition to Aspirin with/without thienopyridine therapy in Subjects with Acute Coronary Syndrome — Thrombolysis In Myocardial Infarction 51) was a randomized, multi-center, double-blind, event-driven trial to determine whether rivaroxaban (2.5 mg twice daily or 5 mg twice daily), when added to standard care (aspirin plus thienopyridine), was safe and effective in reducing the risk of the composite of cardiovascular (CV) death, MI, or stroke in patients with a recent ACS compared with standard care alone.

- Patients (n=15,526) were randomized within 7 days after hospital admission for an ACS event to either rivaroxaban 2.5 mg twice daily, rivaroxaban 5 mg twice daily, or placebo in a 1:1:1 fashion. All patients were to receive standard medical therapy, including low-dose aspirin and a thienopyridine (either clopidogrel or ticlopidine) according to national or local guidelines.
- The primary efficacy endpoint was the composite of CV death, MI, or stroke (ischemic, hemorrhagic, or stroke of uncertain cause). The secondary efficacy endpoint was all-cause death, MI, or stroke. The primary safety endpoint was TIMI major bleeding not related to coronary-artery bypass grafting (CABG) surgery.
- Rivaroxaban + standard care significantly reduced the primary efficacy endpoint of CV death, MI, or stroke, as compared with standard care, 8.9% versus 10.7% (HR 0.84; 95% CI 0.74-0.96; P=0.008). For each component of the primary efficacy endpoint, rivaroxaban + standard care versus standard care yielded a HR of 0.80 (P=0.04), 0.85 (P=0.047), and 1.24 (P=0.25) for CV death, MI, and stroke, respectively.
- The secondary efficacy endpoint of all-cause death, MI, or stroke was reduced by rivaroxaban + standard care as compared to standard care, 9.2% versus 11.0% (HR 0.84; 95% CI 0.74-0.95; P=0.006). Rivaroxaban + standard care reduced the risk of stent thrombosis (definite, probable, or possible), as compared to standard care, with rates of 2.3% and 2.9%, respectively (HR 0.69; 95%CI, 0.51 to 0.93; P= 0.02).
- The 2.5 mg dose of rivaroxaban twice daily + standard care reduced the risk of CV death (2.7% versus 4.1%, P=0.002) and all-cause death (2.9% versus 4.5%, P=0.002) as compared to standard care. These endpoints were not significantly reduced with the rivaroxaban 5 mg twice daily dose + standard care.
- The rate of TIMI major bleeding not related to CABG was significantly increased with rivaroxaban + standard care compared with standard care, 2.1% versus 0.6%, respectively (HR 3.96; 95% CI 2.46-6.38; P<0.001). The rivaroxaban + standard care group vs. the standard care group had higher rates of TIMI minor bleeding (1.3% vs. 0.5%; p=0.003), TIMI bleeding requiring medical attention (14.5% vs. 7.5%; p<0.001), and intracranial hemorrhage (0.6% vs. 0.2%; p=0.009). The rates of fatal bleeding were not significantly different between rivaroxaban + standard care and standard care group (0.3% vs. 0.2%; P= 0.66).
- The rates of TIMI major bleeding not related to CABG were 1.8% in the 2.5 mg rivaroxaban group vs. 2.4% in the 5 mg group (p=0.12). The 2.5 mg dose resulted in significantly lower rates of fatal bleeding than the 5 mg dose, 0.1% versus 0.4%, respectively (P = 0.04) and lower rates of TIMI bleeding requiring medical attention (12.9% vs. 16.2%; p<0.001).

STUDY 3: Phase III study part of the EINSTEIN program that evaluated the use of rivaroxaban alone for anticoagulant therapy for acute pulmonary embolism (PE)

- The Acute PE (EINSTEIN-PE) study³ was a Phase III, randomized, open-label, event-driven, non-inferiority study evaluating the efficacy and safety of oral rivaroxaban (15 mg twice daily for 3 weeks followed by 20 mg once daily) versus subcutaneous enoxaparin 1.0 mg/kg twice daily followed by dose-adjusted oral vitamin K antagonist (VKA, warfarin or acenocoumarol) in patients with acute symptomatic PE with or without deep vein thrombosis (DVT).
 - In this study, a total of 4832 patients (rivaroxaban 2419; enoxaparin-VKA 2413) were enrolled from March 2007 through March 2011.
 - The primary efficacy outcome was symptomatic recurrent VTE, which was defined as a composite of fatal or nonfatal PE or DVT. The principal safety outcome was clinically

relevant bleeding, which was defined as a composite of major or clinically relevant non-major bleeding. Predefined secondary outcomes included major bleeding, death from any cause, vascular events (acute coronary syndrome, ischemic stroke, transient ischemic attack, or systemic embolism), and net clinical benefit (which was defined as a composite of the primary efficacy outcome and major bleeding).

- The primary efficacy outcome occurred in 2.1% of patients in the rivaroxaban group and 1.8% of patients in the enoxaparin-VKA group (HR 1.12; 95% CI 0.75 to 1.68; P=0.003). At 21 days after rivaroxaban administration, the primary efficacy outcome occurred in 0.7% of patients in the rivaroxaban group and 0.9% of patients in the enoxaparin-VKA group. In the safety population, the primary safety outcome occurred in 10.3% of patients in the rivaroxaban group and 11.4% of patients in the enoxaparin-VKA group (HR 0.90; 95% CI 0.76 to 1.07; P=0.23). The net clinical benefit occurred in 3.4% of patients in the rivaroxaban group and 4.0% of patients in the enoxaparin-VKA group (HR 0.85; 95% CI 0.63 to 1.14; P=0.28).
- Major bleeding was observed in 26 patients (1.1%) in the rivaroxaban group and 52 patients (2.2%) in the standard-therapy group (HR 0.49; 95% CI 0.31 to 0.79; P = 0.003). Rates of other adverse events were similar in the two groups.

References:

1. Hankey GJ, Patel MR, Stevens SR, et al. Rivaroxaban compared with warfarin in patients with atrial fibrillation and previous stroke or transient ischaemic attack: a subgroup analysis of ROCKET AF. *Lancet Neurology*. 2012;11:315-22.
2. Mega JL, Braunwald E, Wiviott SD, et al. Rivaroxaban in Patients with a Recent Acute Coronary Syndrome. *NEJM* 2012; 366:9-19.
3. The EINSTEIN Investigators: Buller HR, Prins MH, Lensing AWA, et al. Oral Rivaroxaban for the Treatment of Symptomatic Pulmonary Embolism. [published online ahead of print March 26 2012]. *N Engl J Med* 2012.

XARELTO®

(rivaroxaban) tablets, for oral use

Revised: December 2011
02X12012A**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use XARELTO® (rivaroxaban) safely and effectively. See full prescribing information for XARELTO.

XARELTO (rivaroxaban) tablets, for oral use
Initial U.S. Approval: 2011

WARNINGS: (A) DISCONTINUING XARELTO IN PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION INCREASES RISK OF STROKE, (B) SPINAL/EPIDURAL HEMATOMA

See full prescribing information for complete boxed warning

A. DISCONTINUING XARELTO IN PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION

Discontinuing XARELTO places patients at an increased risk of thrombotic events. If anticoagulation with XARELTO must be discontinued for a reason other than pathological bleeding, consider administering another anticoagulant (2.1, 5.1, 14.1).

B. SPINAL/EPIDURAL HEMATOMA

Epidural or spinal hematomas have occurred in patients treated with XARELTO who are receiving neuraxial anesthesia or undergoing spinal puncture. These hematomas may result in long-term or permanent paralysis (5.2, 5.3, 6.2).

Monitor patients frequently for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary (5.3).

Consider the benefits and risks before neuraxial intervention in patients anticoagulated or to be anticoagulated for thromboprophylaxis (5.3).

-----**RECENT MAJOR CHANGES**-----

Boxed Warning	11/2011
Indications and Usage (1.1)	11/2011
Dosage and Administration (2.1, 2.3)	11/2011
Contraindications (4)	11/2011
Warnings and Precautions (5.1, 5.2, 5.5)	11/2011

-----**INDICATIONS AND USAGE**-----

XARELTO is a factor Xa inhibitor indicated:

- to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (1.1)
- for the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE) in patients undergoing knee or hip replacement surgery (1.2)

-----**DOSAGE AND ADMINISTRATION**-----

- **Nonvalvular Atrial Fibrillation:**
 - o For patients with CrCl >50 mL/min: 20 mg orally, once daily with the evening meal (2.1)
 - o For patients with CrCl 15 - 50 mL/min: 15 mg orally, once daily with the evening meal (2.1)
 - o Avoid use in patients with CrCl <15 mL/min (2.3)
- **Prophylaxis of DVT:** 10 mg orally, once daily with or without food (2.2)
- **Hepatic impairment** (for nonvalvular AF and prophylaxis of DVT indications):
 - o Avoid use in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment or with any degree of hepatic disease associated with coagulopathy (2.3, 8.8).

-----**DOSAGE FORMS AND STRENGTHS**-----

Tablets: 10 mg, 15 mg, and 20 mg (3)

-----**CONTRAINDICATIONS**-----

- Active pathological bleeding (4)
- Severe hypersensitivity reaction to XARELTO (4)

-----**WARNINGS AND PRECAUTIONS**-----

- **Risk of bleeding:** XARELTO can cause serious and fatal bleeding. Promptly evaluate signs and symptoms of blood loss. (5.2)
- **Pregnancy related hemorrhage:** Use XARELTO with caution in pregnant women due to the potential for obstetric hemorrhage and/or emergent delivery. Promptly evaluate signs and symptoms of blood loss. (5.4)

-----**ADVERSE REACTIONS**-----

The most common adverse reaction (>5%) was bleeding. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Janssen Pharmaceuticals, Inc. at 1-800-526-7736 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

-----**DRUG INTERACTIONS**-----

- Combined P-gp and strong CYP3A4 inhibitors and inducers: Avoid concomitant use (7.1, 7.2)
- **Prophylaxis of DVT:**
 - o Anticoagulants: Avoid concomitant use (7.3)

XARELTO® (rivaroxaban) tablets

-----**USE IN SPECIFIC POPULATIONS**-----

- Nursing mothers: discontinue drug or discontinue nursing (8.3)
- Renal impairment:
 - o **Prophylaxis of DVT:** Avoid use in patients with severe impairment (CrCl <30 mL/min). Use with caution in moderate impairment (CrCl 30 to <50 mL/min) (8.7)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 12/2011

FULL PRESCRIBING INFORMATION: CONTENTS*

WARNINGS: (A) DISCONTINUING XARELTO IN PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION INCREASES RISK OF STROKE, (B) SPINAL/EPIDURAL HEMATOMA

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- 1.2 Prophylaxis of Deep Vein Thrombosis

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FULL PRESCRIBING INFORMATION

WARNINGS: (A) DISCONTINUING XARELTO IN PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION INCREASES RISK OF STROKE, (B) SPINAL/EPIDURAL HEMATOMA**A. DISCONTINUING XARELTO IN PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION**

Discontinuing XARELTO places patients at an increased risk of thrombotic events. An increased rate of stroke was observed following XARELTO discontinuation in clinical trials in atrial fibrillation patients. If anticoagulation with XARELTO must be discontinued for a reason other than pathological bleeding, consider administering another anticoagulant [see *Dosage and Administration* (2.1), *Warnings and Precautions* (5.1), and *Clinical Studies* (14.1)].

B. SPINAL/EPIDURAL HEMATOMA

Epidural or spinal hematomas have occurred in patients treated with XARELTO who are receiving neuraxial anesthesia or undergoing spinal puncture. These hematomas may result in long-term or permanent paralysis. Consider these risks when scheduling patients for spinal procedures. Factors that can increase the risk of developing epidural or spinal hematomas in these patients include:

- use of indwelling epidural catheters
- concomitant use of other drugs that affect hemostasis, such as non-steroidal anti-inflammatory drugs (NSAIDs), platelet inhibitors, other anticoagulants
- a history of traumatic or repeated epidural or spinal punctures
- a history of spinal deformity or spinal surgery [see *Warnings and Precautions* (5.2, 5.3) and *Adverse Reactions* (6.2)].

Monitor patients frequently for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary [see *Warnings and Precautions* (5.3)].

Consider the benefits and risks before neuraxial intervention in patients anticoagulated or to be anticoagulated for thromboprophylaxis [see *Warnings and Precautions* (5.3)].

1 INDICATIONS AND USAGE**1.1 Reduction of Risk of Stroke and Systemic Embolism in Nonvalvular Atrial Fibrillation**

XARELTO (rivaroxaban) is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation.

There are limited data on the relative effectiveness of XARELTO and warfarin in reducing the risk of stroke and systemic embolism when warfarin therapy is well-controlled [see *Clinical Studies* (14.1)].

1.2 Prophylaxis of Deep Vein Thrombosis

XARELTO (rivaroxaban) is indicated for the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE) in patients undergoing knee or hip replacement surgery.

2 DOSAGE AND ADMINISTRATION**2.1 Nonvalvular Atrial Fibrillation**

For patients with creatinine clearance (CrCl) >50 mL/min, the recommended dose of XARELTO is 20 mg taken orally once daily with the evening meal. For patients with CrCl 15 to 50 mL/min, the recommended dose is 15 mg once daily with the evening meal [see *Use in Specific Populations* (8.7)].

Switching from or to Warfarin - When switching patients from warfarin to XARELTO, discontinue warfarin and start XARELTO as soon as the International Normalized Ratio (INR) is below 3.0 to avoid periods of inadequate anticoagulation.

No clinical trial data are available to guide converting patients from XARELTO to warfarin. XARELTO affects INR, so INR measurements made during co-administration with warfarin may not be useful for determining the appropriate dose of warfarin. One approach is to discontinue XARELTO and begin both a parenteral anticoagulant and warfarin at the time the next dose of XARELTO would have been taken.

Switching from or to Anticoagulants other than Warfarin - For patients currently receiving an anticoagulant other than warfarin, start XARELTO 0 to 2 hours prior to the next scheduled evening administration of the drug (e.g., low molecular weight heparin or non-warfarin oral anticoagulant) and omit administration of the other anticoagulant. For unfractionated heparin being administered by continuous infusion, stop the infusion and start XARELTO at the same time.

For patients currently taking XARELTO and transitioning to an anticoagulant with rapid onset, discontinue XARELTO and give the first dose of the other anticoagulant (oral or parenteral) at the time that the next XARELTO dose would have been taken [see *Drug Interactions* (7.3)].

2.2 Prophylaxis of Deep Vein Thrombosis

The recommended dose of XARELTO is 10 mg taken orally once daily with or without food. The initial dose should be taken at least 6 to 10 hours after surgery once hemostasis has been established.

- For patients undergoing hip replacement surgery, treatment duration of 35 days is recommended.

- For patients undergoing knee replacement surgery, treatment duration of 12 days is recommended.

2.3 General Dosing Instructions**Hepatic Impairment**

No clinical data are available for patients with severe hepatic impairment. Avoid use of XARELTO in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment or with any hepatic disease associated with coagulopathy [see *Use in Specific Populations* (8.8)].

Renal Impairment**Nonvalvular Atrial Fibrillation**

Avoid the use of XARELTO in patients with CrCl <15 mL/min. Periodically assess renal function as clinically indicated (i.e., more frequently in situations in which renal function may decline) and adjust therapy accordingly. Discontinue XARELTO in patients who develop acute renal failure while on XARELTO [see *Use in Specific Populations* (8.7)].

Prophylaxis of Deep Vein Thrombosis

Avoid the use of XARELTO in patients with severe renal impairment (CrCl <30 mL/min) due to an expected increase in rivaroxaban exposure and pharmacodynamic effects in this patient population. Observe closely and promptly evaluate any signs or symptoms of blood loss in patients with moderate renal impairment (CrCl 30 to 50 mL/min). Patients who develop acute renal failure while on XARELTO should discontinue the treatment [see *Use in Specific Populations* (8.7)].

Surgery and Intervention

If anticoagulation must be discontinued to reduce the risk of bleeding with surgical or other procedures, XARELTO should be stopped at least 24 hours before the procedure. In deciding whether a procedure should be delayed until 24 hours after the last dose of XARELTO, the increased risk of bleeding should be weighed against the urgency of intervention. XARELTO should be restarted after the surgical or other procedures as soon as adequate hemostasis has been established. If oral medication cannot be taken after surgical intervention, consider administering a parenteral anticoagulant.

Missed Dose

If a dose of XARELTO is not taken at the scheduled time, administer the dose as soon as possible on the same day.

Use with P-gp and Strong CYP3A4 Inhibitors or Inducers

Avoid concomitant use of XARELTO with combined P-gp and strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, lopinavir/ritonavir, ritonavir, indinavir/ritonavir, and cobicistat) [see *Drug Interactions* (7.1)].

Avoid concomitant use of XARELTO with drugs that are combined P-gp and strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, rifampin, St. John's wort) [see *Drug Interactions* (7.2)].

3 DOSAGE FORMS AND STRENGTHS

- 10 mg tablets: Round, light red, biconvex and film-coated with a triangle pointing down above a "10" marked on one side and "Xa" on the other side
- 15 mg tablets: Round, red, biconvex, and film-coated with a triangle pointing down above a "15" marked on one side and "Xa" on the other side
- 20 mg tablets: Triangle-shaped, dark red, and film-coated with a triangle pointing down above a "20" marked on one side and "Xa" on the other side

4 CONTRAINDICATIONS

XARELTO is contraindicated in patients with:

- active pathological bleeding [see *Warnings and Precautions* (5.2)]
- severe hypersensitivity reaction to XARELTO [see *Warnings and Precautions* (5.5)]

5 WARNINGS AND PRECAUTIONS**5.1 Increased Risk of Stroke after Discontinuation in Nonvalvular Atrial Fibrillation**

Discontinuing XARELTO in the absence of adequate alternative anticoagulation increases the risk of thrombotic events. An increased rate of stroke was observed during the transition from XARELTO to warfarin in clinical trials in atrial fibrillation patients. If XARELTO must be discontinued for a reason other than pathological bleeding, consider administering another anticoagulant [see *Dosage and Administration* (2.1) and *Clinical Studies* (14.1)].

5.2 Risk of Bleeding

XARELTO increases the risk of bleeding and can cause serious or fatal bleeding. In deciding whether to prescribe XARELTO to patients at increased risk of bleeding, the risk of thrombotic events should be weighed against the risk of bleeding.

Promptly evaluate any signs or symptoms of blood loss. Discontinue XARELTO in patients with active pathological hemorrhage.

A specific antidote for rivaroxaban is not available. Because of high plasma protein binding, rivaroxaban is not expected to be dialyzable [see *Clinical Pharmacology* (12.3)]. Protamine sulfate and vitamin K are not expected to affect the anticoagulant activity of rivaroxaban. There is no experience with antifibrinolytic agents (tranexamic acid, aminocaproic acid) in individuals receiving rivaroxaban. There is neither scientific rationale for benefit nor experience with systemic hemostatics (desmopressin and aprotinin) in

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individuals receiving rivaroxaban. Use of procoagulant reversal agents such as prothrombin complex concentrate (PCC), activated prothrombin complex concentrate (APCC), or recombinant factor VIIa (rFVIIa) may be considered, but has not been evaluated in clinical trials.

Concomitant use of drugs affecting hemostasis increases the risk of bleeding. These include aspirin, P2Y₁₂ platelet inhibitors, other antithrombotic agents, fibrinolytic therapy, and non-steroidal anti-inflammatory drugs (NSAIDs) [see *Drug Interactions* (7.3), (7.4), (7.5)].

Concomitant use of drugs that are combined P-gp and CYP3A4 inhibitors (e.g. ketoconazole and ritonavir) increases rivaroxaban exposure and may increase bleeding risk [see *Drug Interactions* (7.1)].

5.3 Spinal/Epidural Anesthesia or Puncture

When neuraxial anesthesia (spinal/epidural anesthesia) or spinal puncture is employed, patients treated with anticoagulant agents for prevention of thromboembolic complications are at risk of developing an epidural or spinal hematoma which can result in long-term or permanent paralysis [see *Boxed Warning*].

An epidural catheter should not be removed earlier than 18 hours after the last administration of XARELTO. The next XARELTO dose is not to be administered earlier than 6 hours after the removal of the catheter. If traumatic puncture occurs, the administration of XARELTO is to be delayed for 24 hours.

5.4 Risk of Pregnancy Related Hemorrhage

XARELTO should be used with caution in pregnant women and only if the potential benefit justifies the potential risk to the mother and fetus. XARELTO dosing in pregnancy has not been studied. The anticoagulant effect of XARELTO cannot be monitored with standard laboratory testing nor readily reversed. Promptly evaluate any signs or symptoms suggesting blood loss (e.g., a drop in hemoglobin and/or hematocrit, hypotension, or fetal distress).

5.5 Severe Hypersensitivity Reactions

There were postmarketing cases of anaphylaxis in patients treated with XARELTO to reduce the risk of DVT. Patients who have a history of a severe hypersensitivity reaction to XARELTO should not receive XARELTO [see *Adverse Reactions* (6.2)].

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

During clinical development for the approved indications, 11598 patients were exposed to XARELTO. These included 7111 patients who received XARELTO 15 mg or 20 mg orally once daily for a mean of 19 months (5558 for 12 months and 2512 for 24 months) to reduce the risk of stroke and systemic embolism in nonvalvular atrial fibrillation (ROCKET AF) and 4487 patients who received XARELTO 10 mg orally once daily for prophylaxis of DVT following hip or knee replacement surgery (RECORD 1-3).

Hemorrhage

The most common adverse reactions with XARELTO were bleeding complications [see *Warnings and Precautions* (5.2)].

Nonvalvular Atrial Fibrillation

In the ROCKET AF trial, the most frequent adverse reactions associated with permanent drug discontinuation were bleeding events, with incidence rates of 4.3% for XARELTO vs. 3.1% for warfarin. The incidence of discontinuations for non-bleeding adverse events was similar in both treatment groups.

Table 1 shows the number of patients experiencing various types of bleeding events in the ROCKET AF study.

Table 1: Bleeding Events in ROCKET AF*

Parameter	XARELTO N = 7111 n (%)	Event Rate (per 100 Pt-yrs)	Warfarin N = 7125 n (%)	Event Rate (per 100 Pt-yrs)
Major bleeding†	395 (5.6)	3.6	386 (5.4)	3.5
Bleeding into a critical organ‡	91 (1.3)	0.8	133 (1.9)	1.2
Fatal bleeding	27 (0.4)	0.2	55 (0.8)	0.5
Bleeding resulting in transfusion of ≥ 2 units of whole blood or packed red blood cells	183 (2.6)	1.7	149 (2.1)	1.3
Gastrointestinal bleeding	221 (3.1)	2.0	140 (2.0)	1.2

*For all sub-types of major bleeding, single events may be represented in more than one row, and individual patients may have more than one event.

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† Defined as clinically overt bleeding associated with a decrease in hemoglobin of ≥ 2 g/dL, transfusion of ≥ 2 units of packed red blood cells or whole blood, bleeding at a critical site, or with a fatal outcome. Hemorrhagic strokes are counted as both bleeding and efficacy events. Major bleeding rates excluding strokes are 3.3 per 100 Pt-yrs for XARELTO vs. 2.9 per 100 Pt-yrs for warfarin.

‡ The majority of the events were intracranial, and also included intraspinal, intraocular, pericardial, intraarticular, intramuscular with compartment syndrome, or retroperitoneal.

Prophylaxis of Deep Vein Thrombosis

In the RECORD clinical trials, the overall incidence rate of adverse reactions leading to permanent treatment discontinuation was 3.7% with XARELTO.

The mean duration of XARELTO treatment was 11.9 days in the total knee replacement study and 33.4 days in the total hip replacement studies. Overall, in the RECORD program, the mean age of the patients studied in the XARELTO group was 64 years, 59% were female and 82% were Caucasian. Twenty-seven percent (1206) of patients underwent knee replacement surgery and 73% (3281) underwent hip replacement surgery.

The rates of major bleeding events and any bleeding events observed in patients in the RECORD clinical trials are shown in Table 2.

Table 2: Bleeding Events* in Patients Undergoing Hip or Knee Replacement Surgeries (RECORD 1-3)

	XARELTO 10 mg N = 4487 n (%)	Enoxaparin† N = 4524 n (%)
Total treated patients		
Major bleeding event	14 (0.3)	9 (0.2)
Fatal bleeding	1 (<0.1)	0
Bleeding into a critical organ	2 (<0.1)	3 (0.1)
Bleeding that required re-operation	7 (0.2)	5 (0.1)
Extra-surgical site bleeding requiring transfusion of >2 units of whole blood or packed cells	4 (0.1)	1 (<0.1)
Any bleeding event‡	261 (5.8)	251 (5.6)
Hip Surgery Studies	N = 3281 n (%)	N = 3298 n (%)
Major bleeding event	7 (0.2)	3 (0.1)
Fatal bleeding	1 (<0.1)	0
Bleeding into a critical organ	1 (<0.1)	1 (<0.1)
Bleeding that required re-operation	2 (0.1)	1 (<0.1)
Extra-surgical site bleeding requiring transfusion of >2 units of whole blood or packed cells	3 (0.1)	1 (<0.1)
Any bleeding event‡	201 (6.1)	191 (5.8)
Knee Surgery Study	N = 1206 n (%)	N = 1226 n (%)
Major bleeding event	7 (0.6)	6 (0.5)
Fatal bleeding	0	0
Bleeding into a critical organ	1 (0.1)	2 (0.2)
Bleeding that required re-operation	5 (0.4)	4 (0.3)
Extra-surgical site bleeding requiring transfusion of >2 units of whole blood or packed cells	1 (0.1)	0
Any bleeding event‡	60 (5.0)	60 (4.9)

* Bleeding events occurring any time following the first dose of double-blind study medication (which may have been prior to administration of active drug) until two days after the last dose of double-blind study medication. Patients may have more than one event.

† Includes the placebo-controlled period for RECORD 2, enoxaparin dosing was 40 mg once daily (RECORD 1-3)

‡ Includes major bleeding events

Following XARELTO treatment, the majority of major bleeding complications (≥60%) occurred during the first week after surgery.

Other Adverse Reactions

Non-hemorrhagic adverse drug reactions (ADRs) reported in ≥1% of XARELTO-treated patients are shown in Table 3.

Table 3: Other Adverse Drug Reactions* Reported by ≥1% of XARELTO-Treated Patients in RECORD 1-3 Studies

System/Organ Class Adverse Reaction	XARELTO 10 mg (N = 4487) n (%)	Enoxaparin† (N = 4524) n (%)
Injury, poisoning and procedural complications		
Wound secretion	125 (2.8)	89 (2.0)
Musculoskeletal and connective tissue disorders		
Pain in extremity	74 (1.7)	55 (1.2)
Muscle spasm	52 (1.2)	32 (0.7)
Nervous system disorders		
Syncope	55 (1.2)	32 (0.7)
Skin and subcutaneous tissue disorders		
Pruritus	96 (2.1)	79 (1.8)
Blister	63 (1.4)	40 (0.9)

* ADR occurring any time following the first dose of double-blind medication, which may have been prior to administration of active drug, until two days after the last dose of double-blind study medication.

† Includes the placebo-controlled period of RECORD 2, enoxaparin dosing was 40 mg once daily (RECORD 1-3)

Other clinical trial experience: In an investigational study of acute medically ill patients being treated with XARELTO 10 mg tablets, cases of pulmonary hemorrhage and pulmonary hemorrhage with bronchiectasis were observed.

6.2 Postmarketing Experience

The following adverse reactions have been identified during post-approval use of rivaroxaban. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Blood and lymphatic system disorders: agranulocytosis

Gastrointestinal disorders: retroperitoneal hemorrhage

Hepatobiliary disorders: jaundice, cholestasis, cytolytic hepatitis

Immune system disorders: hypersensitivity, anaphylactic reaction, anaphylactic shock

Nervous system disorders: cerebral hemorrhage, subdural hematoma, epidural hematoma, hemiparesis

Skin and subcutaneous tissue disorders: Stevens-Johnson syndrome

7 DRUG INTERACTIONS

Rivaroxaban is a substrate of CYP3A4/5, CYP2J2, and the P-gp and ATP-binding cassette G2 (ABCG2) transporters. Inhibitors and inducers of these CYP450 enzymes or transporters (e.g., P-gp) may result in changes in rivaroxaban exposure.

7.1 Drugs that Inhibit Cytochrome P450 3A4 Enzymes and Drug Transport Systems

In drug interaction studies evaluating the concomitant use with drugs that are combined P-gp and CYP3A4 inhibitors, increases in rivaroxaban exposure and pharmacodynamic effects (i.e., factor Xa inhibition and PT prolongation) were observed. Significant increases in rivaroxaban exposure may increase bleeding risk.

- **Ketoconazole (combined P-gp and strong CYP3A4 inhibitor):** Steady-state rivaroxaban AUC and C_{max} increased by 160% and 70%, respectively. Similar increases in pharmacodynamic effects were also observed.
- **Ritonavir (combined P-gp and strong CYP3A4 inhibitor):** Single-dose rivaroxaban AUC and C_{max} increased by 150% and 60%, respectively. Similar increases in pharmacodynamic effects were also observed.
- **Clarithromycin (combined P-gp and strong CYP3A4 inhibitor):** Single-dose rivaroxaban AUC and C_{max} increased by 50% and 40%, respectively. The smaller increases in exposure observed for clarithromycin compared to ketoconazole or ritonavir may be due to the relative difference in P-gp inhibition.
- **Erythromycin (combined P-gp and moderate CYP3A4 inhibitor):** Both the single-dose rivaroxaban AUC and C_{max} increased by 30%.
- **Fluconazole (moderate CYP3A4 inhibitor):** Single-dose rivaroxaban AUC and C_{max} increased by 40% and 30%, respectively.

Avoid concomitant administration of XARELTO with combined P-gp and strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, lopinavir/ritonavir, ritonavir, indinavir/ritonavir, and conivaptan), which cause significant increases in rivaroxaban exposure that may increase bleeding risk.

Prophylaxis of Deep Vein Thrombosis

When clinical data suggest a change in exposure is unlikely to affect bleeding risk (e.g., clarithromycin, erythromycin), no precautions are necessary during coadministration with drugs that are combined P-gp and CYP3A4 inhibitors.

7.2 Drugs that Induce Cytochrome P450 3A4 Enzymes and Drug Transport Systems

In a drug interaction study, co-administration of XARELTO (20 mg single dose with food) with a drug that is a combined P-gp and strong CYP3A4 inducer (rifampicin titrated up to 600 mg once daily) led to an approximate decrease of 50% and 22% in AUC and C_{max} , respectively. Similar decreases in pharmacodynamic effects were also observed. These decreases in exposure to rivaroxaban may decrease efficacy.

Avoid concomitant use of XARELTO with drugs that are combined P-gp and strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, rifampin, St. John's wort).

7.3 Anticoagulants

In a drug interaction study, single doses of enoxaparin (40 mg subcutaneous) and XARELTO (10 mg) given concomitantly resulted in an additive effect on anti-factor Xa activity. Enoxaparin did not affect the pharmacokinetics of rivaroxaban. In another study, single doses of warfarin (15 mg) and XARELTO (5 mg) resulted in an additive effect on factor Xa inhibition and PT. Warfarin did not affect the pharmacokinetics of rivaroxaban.

Prophylaxis of Deep Vein Thrombosis

Avoid concurrent use of XARELTO with other anticoagulants due to the increased bleeding risk. Promptly evaluate any signs or symptoms of blood loss [see Warnings and Precautions (5.2)].

7.4 NSAIDs/Aspirin

In ROCKET AF, concomitant aspirin use (almost exclusively at a dose of 100 mg or less) during the double-blind phase was identified as an independent risk factor for major bleeding. NSAIDs are known to increase bleeding, and bleeding risk may be increased when NSAIDs are used concomitantly with XARELTO. In a single-dose drug interaction study there were no pharmacokinetic or pharmacodynamic interactions observed after concomitant administration of naproxen or aspirin (acetylsalicylic acid) with XARELTO.

Promptly evaluate any signs or symptoms of blood loss if patients are treated concomitantly with aspirin, other platelet aggregation inhibitors, or NSAIDs [see Warnings and Precautions (5.2)].

7.5 Clopidogrel

In two drug interaction studies where clopidogrel (300 mg loading dose followed by 75 mg daily maintenance dose) and XARELTO (15 mg single dose) were co-administered in healthy subjects, an increase in bleeding time to 45 minutes was observed in approximately 45% and 30% of subjects in these studies, respectively. The change in bleeding time was approximately twice the maximum increase seen with either drug alone. There was no change in the pharmacokinetics of either drug.

Promptly evaluate any signs or symptoms of blood loss if patients are treated concomitantly with clopidogrel [see Warnings and Precautions (5.2)].

7.6 Drug-Disease Interactions with Drugs that Inhibit Cytochrome P450 3A4 Enzymes and Drug Transport Systems

Based on simulated pharmacokinetic data, patients with renal impairment receiving full dose XARELTO in combination with drugs classified as combined P-gp and weak or moderate CYP3A4 inhibitors (e.g., amiodarone, diltiazem, verapamil, quinidine, ranolazine, dronedarone, felodipine, erythromycin, and azithromycin) may have significant increases in exposure compared with patients with normal renal function and no inhibitor use, since both pathways of rivaroxaban elimination are affected.

While increases in rivaroxaban exposure can be expected under such conditions, results from an analysis in the ROCKET AF trial, which allowed concomitant use with combined P-gp and weak or moderate CYP3A4 inhibitors (e.g., amiodarone, diltiazem, verapamil, chloramphenicol, cimetidine, and erythromycin), did not show an increase in bleeding in patients with CrCl 30 to <50 mL/min [Hazard Ratio (95% CI): 1.05 (0.77, 1.42)]. XARELTO should be used in patients with CrCl 15 to 50 mL/min who are receiving concomitant combined P-gp and weak or moderate CYP3A4 inhibitors only if the potential benefit justifies the potential risk [see Use in Specific Populations (8.7)].

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C

There are no adequate or well-controlled studies of XARELTO in pregnant women, and dosing for pregnant women has not been established. Use XARELTO with caution in pregnant patients because of the potential for pregnancy related hemorrhage and/or emergent delivery with an anticoagulant that is not readily reversible. The anticoagulant effect of XARELTO cannot be reliably monitored with standard laboratory testing. Animal reproduction studies showed no increased risk of structural malformations, but increased post-implantation

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pregnancy loss occurred in rabbits. XARELTO should be used during pregnancy only if the potential benefit justifies the potential risk to mother and fetus [see *Warnings and Precautions* (5.4)].

Rivaroxaban crosses the placenta in animals. Animal reproduction studies have shown pronounced maternal hemorrhagic complications in rats and an increased incidence of post-implantation pregnancy loss in rabbits. Rivaroxaban increased fetal toxicity (increased resorptions, decreased number of live fetuses, and decreased fetal body weight) when pregnant rabbits were given oral doses of ≥ 10 mg/kg rivaroxaban during the period of organogenesis. This dose corresponds to about 4 times the human exposure of unbound drug, based on AUC comparisons at the highest recommended human dose of 20 mg/day. Fetal body weights decreased when pregnant rats were given oral doses of 120 mg/kg. This dose corresponds to about 14 times the human exposure of unbound drug.

8.2 Labor and Delivery

Safety and effectiveness of XARELTO during labor and delivery have not been studied in clinical trials. However, in animal studies maternal bleeding and maternal and fetal death occurred at the rivaroxaban dose of 40 mg/kg (about 6 times maximum human exposure of the unbound drug at the human dose of 20 mg/day).

8.3 Nursing Mothers

It is not known if rivaroxaban is excreted in human milk. Rivaroxaban and/or its metabolites were excreted into the milk of rats. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from rivaroxaban, a decision should be made whether to discontinue nursing or discontinue XARELTO, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.5 Geriatric Use

Of the total number of patients in the RECORD 1-3 clinical studies evaluating XARELTO, about 54% were 65 years and over, while about 15% were >75 years. In ROCKET AF, approximately 77% were 65 years and over and about 38% were >75 years. In clinical trials the efficacy of XARELTO in the elderly (65 years or older) was similar to that seen in patients younger than 65 years. Both thrombotic and bleeding event rates were higher in these older patients, but the risk-benefit profile was favorable in all age groups [see *Clinical Pharmacology* (12.3) and *Clinical Studies* (14)].

8.6 Females of Reproductive Potential

Females of reproductive potential requiring anticoagulation should discuss pregnancy planning with their physician.

8.7 Renal Impairment

The safety and pharmacokinetics of single-dose XARELTO (10 mg) were evaluated in a study in healthy subjects [$\text{CrCl} \geq 80$ mL/min ($n=8$)] and in subjects with varying degrees of renal impairment (see Table 4). Compared to healthy subjects with normal creatinine clearance, rivaroxaban exposure increased in subjects with renal impairment. Increases in pharmacodynamic effects were also observed.

Table 4: Percent Increase of Rivaroxaban PK and PD Parameters from Normal in Subjects with Renal Insufficiency from a Dedicated Renal Impairment Study

Parameter		Renal Impairment Class (CrCl (mL/min))		
		Mild [50 to 79] N=8	Moderate [30 to 49] N=8	Severe [15 to 29] N=8
Exposure (% increase relative to normal)	AUC C_{\max}	44 28	52 12	64 26
FXa Inhibition (% increase relative to normal)	AUC E_{\max}	50 9	86 10	100 12
PT Prolongation (% increase relative to normal)	AUC E_{\max}	33 4	116 17	144 20

PT = Prothrombin time; FXa = Coagulation factor Xa; AUC = Area under the concentration or effect curve; C_{\max} = maximum concentration; E_{\max} = maximum effect; and CrCl = creatinine clearance

Patients with renal impairment taking P-gp and weak to moderate CYP3A4 inhibitors may have significant increases in exposure which may increase bleeding risk [see *Drug Interactions* (7.6)].

Nonvalvular Atrial Fibrillation

In the ROCKET AF trial, patients with CrCl 30 to 50 mL/min were administered XARELTO 15 mg once daily resulting in serum concentrations of rivaroxaban and clinical outcomes similar to those in patients with better renal function

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administered XARELTO 20 mg once daily. Patients with CrCl 15 to 30 mL/min were not studied, but administration of XARELTO 15 mg once daily is also expected to result in serum concentrations of rivaroxaban similar to those in patients with normal renal function [see *Dosage and Administration* (2.1)].

Prophylaxis of Deep Vein Thrombosis

The combined analysis of the RECORD 1-3 clinical efficacy studies did not show an increase in bleeding risk for patients with moderate renal impairment and reported a possible increase in total VTE in this population. Observe closely and promptly evaluate any signs or symptoms of blood loss in patients with moderate renal impairment (CrCl 30 to <50 mL/min). Avoid the use of XARELTO in patients with severe renal impairment (CrCl <30 mL/min) [see *Dosage and Administration* (2.3) and *Warnings and Precautions* (5.2)].

8.8 Hepatic Impairment

The safety and pharmacokinetics of single-dose XARELTO (10 mg) were evaluated in a study in healthy subjects ($n=16$) and subjects with varying degrees of hepatic impairment (see Table 5). No patients with severe hepatic impairment (Child-Pugh C) were studied. Compared to healthy subjects with normal liver function, significant increases in rivaroxaban exposure were observed in subjects with moderate hepatic impairment (Child-Pugh B). Increases in pharmacodynamic effects were also observed.

Table 5: Percent Increase of Rivaroxaban PK and PD Parameters from Normal in Subjects with Hepatic Insufficiency from a Dedicated Hepatic Impairment Study

Parameter		Hepatic Impairment Class (Child-Pugh Class)	
		Mild (Child-Pugh A) N=8	Moderate (Child-Pugh B) N=8
Exposure (% increase relative to normal)	AUC C_{\max}	15 0	127 27
FXa Inhibition (% increase relative to normal)	AUC E_{\max}	8 0	159 24
PT Prolongation (% increase relative to normal)	AUC E_{\max}	6 2	114 41

PT = Prothrombin time; FXa = Coagulation factor Xa; AUC = Area under the concentration or effect curve; C_{\max} = maximum concentration; E_{\max} = maximum effect

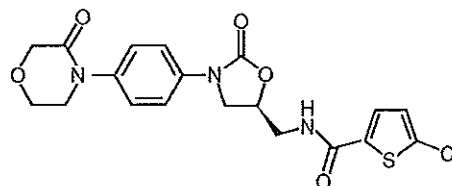
Avoid the use of XARELTO in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment or with any hepatic disease associated with coagulopathy [see *Dosage and Administration* (2.3) and *Warnings and Precautions* (5.2)].

10 OVERDOSAGE

Overdose of XARELTO may lead to hemorrhage. A specific antidote for rivaroxaban is not available. Rivaroxaban systemic exposure is not further increased at single doses >50 mg due to limited absorption. Discontinue XARELTO and initiate appropriate therapy if bleeding complications associated with overdose occur. The use of activated charcoal to reduce absorption in case of XARELTO overdose may be considered. Due to the high plasma protein binding, rivaroxaban is not expected to be dialyzable [see *Warnings and Precautions* (5.2) and *Clinical Pharmacology* (12.3)].

11 DESCRIPTION

Rivaroxaban, a factor Xa inhibitor, is the active ingredient in XARELTO Tablets with the chemical name 5-Chloro-N-((5S)-2-oxo-3-[4-(3-oxo-4-morpholinyl)phenyl]-1,3-oxazolidin-5-yl)methyl)-2-thiophenecarboxamide. The molecular formula of rivaroxaban is $\text{C}_{19}\text{H}_{18}\text{ClN}_3\text{O}_5\text{S}$ and the molecular weight is 435.89. The structural formula is:



Rivaroxaban is a pure (S)-enantiomer. It is an odorless, non-hygroscopic, white to yellowish powder. Rivaroxaban is only slightly soluble in organic solvents (e.g., acetone, polyethylene glycol 400) and is practically insoluble in water and aqueous media.

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Each XARELTO tablet contains 10 mg, 15 mg, or 20 mg of rivaroxaban. The inactive ingredients of XARELTO are: croscarmellose sodium, hypromellose, lactose monohydrate, magnesium stearate, microcrystalline cellulose, and sodium lauryl sulfate. Additionally, the proprietary film coating mixture used for XARELTO 10 mg tablets is Opadry® Pink and XARELTO 15 mg tablets is Opadry® Red, containing ferric oxide red, hypromellose, polyethylene glycol 3350, and titanium dioxide, and for XARELTO 20 mg tablets is Opadry® II Dark Red, containing ferric oxide red, polyethylene glycol 3350, polyvinyl alcohol (partially hydrolyzed), talc, and titanium dioxide.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

XARELTO is an orally bioavailable factor Xa inhibitor that selectively blocks the active site of factor Xa and does not require a cofactor (such as Anti-thrombin III) for activity. Activation of factor X to factor Xa (FXa) via the intrinsic and extrinsic pathways plays a central role in the cascade of blood coagulation.

12.2 Pharmacodynamics

Dose-dependent inhibition of factor Xa activity was observed in humans and the Neoplastin® prothrombin time (PT), activated partial thromboplastin time (aPTT) and HepTest® are prolonged dose-dependently. Anti-factor Xa activity is also influenced by rivaroxaban.

12.3 Pharmacokinetics

Absorption

The absolute bioavailability of rivaroxaban is dose-dependent. For the 10 mg dose, it is estimated to be 80% to 100% and is not affected by food. XARELTO 10 mg tablets can be taken with or without food [see *Dosage and Administration* (2.2)].

The absolute bioavailability of rivaroxaban at a dose of 20 mg in the fasted state is approximately 66%. Coadministration of XARELTO with food increases the bioavailability of the 20 mg dose (mean AUC and C_{max} increasing by 39% and 76% respectively with food). XARELTO 15 mg and 20 mg tablets should be taken with the evening meal [see *Dosage and Administration* (2.1)].

The maximum concentrations (C_{max}) of rivaroxaban appear 2 to 4 hours after tablet intake. The pharmacokinetics of rivaroxaban were not affected by drugs altering gastric pH. Coadministration of XARELTO (30 mg single dose) with the H₂-receptor antagonist ranitidine (150 mg twice daily), the antacid aluminum hydroxide/magnesium hydroxide (10 mL) or XARELTO (20 mg single dose) with the PPI omeprazole (40 mg once daily) did not show an effect on the bioavailability and exposure of rivaroxaban.

Absorption of rivaroxaban is dependent on the site of drug release in the GI tract. A 29% and 56% decrease in AUC and C_{max} compared to tablet was reported when rivaroxaban granulate is released in the proximal small intestine. Exposure is further reduced when drug is released in the distal small intestine, or ascending colon. Avoid administration of rivaroxaban via a method that could deposit drug directly into the proximal small intestine (e.g., feeding tube) which can result in reduced absorption and related drug exposure.

Distribution

Plasma protein binding of rivaroxaban in human plasma is approximately 92% to 95%, with albumin being the main binding component. The steady-state volume of distribution in healthy subjects is approximately 50 L.

Metabolism

Approximately 51% of an orally administered [¹⁴C]-rivaroxaban dose was recovered as metabolites in urine (30%) and feces (21%). Oxidative degradation catalyzed by CYP3A4/5 and CYP2J2 and hydrolysis are the major sites of biotransformation. Unchanged rivaroxaban was the predominant moiety in plasma with no major or active circulating metabolites.

Excretion

Following oral administration of a [¹⁴C]-rivaroxaban dose, 66% of the radioactive dose was recovered in urine (36% as unchanged drug) and 28% was recovered in feces (7% as unchanged drug). Unchanged drug is excreted into urine, mainly via active tubular secretion and to a lesser extent via glomerular filtration (approximate 5:1 ratio). Rivaroxaban is a substrate of the efflux transporter proteins P-gp and ABCG2 (also abbreviated Bcrp). Rivaroxaban's affinity for influx transporter proteins is unknown.

Rivaroxaban is a low-clearance drug, with a systemic clearance of approximately 10 L/hr in healthy volunteers following intravenous administration. The terminal elimination half-life of rivaroxaban is 5 to 9 hours in healthy subjects aged 20 to 45 years.

Specific Populations

Gender

Gender did not influence the pharmacokinetics or pharmacodynamics of XARELTO.

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Race

Healthy Japanese subjects were found to have 20 to 40% on average, higher exposures compared to other ethnicities including Chinese. However, these differences in exposure are reduced when values are corrected for body weight.

Elderly

In clinical studies, elderly subjects exhibited higher rivaroxaban plasma concentrations than younger subjects with mean AUC values being approximately 50% higher, mainly due to reduced (apparent) total body and renal clearance. Age related changes in renal function may play a role in this age effect. The terminal elimination half-life is 11 to 13 hours in the elderly [see *Use in Specific Populations* (8.5)].

Body Weight

Extremes in body weight (<50 kg or >120 kg) did not influence (less than 25%) rivaroxaban exposure.

Drug Interactions

In vitro studies indicate that rivaroxaban neither inhibits the major cytochrome P450 enzymes CYP1A2, 2C8, 2C9, 2C19, 2D6, 2J2, and 3A4 nor induces CYP1A2, 2B6, 2C19, or 3A4.

In vitro data also indicates a low rivaroxaban inhibitory potential for P-gp and ABCG2 transporters.

In addition, there were no significant pharmacokinetic interactions observed in studies comparing concomitant rivaroxaban 20 mg and 7.5 mg single dose of midazolam (substrate of CYP3A4), 0.375 mg once-daily dose of digoxin (substrate of P-gp), or 20 mg once daily dose of atorvastatin (substrate of CYP3A4 and P-gp) in healthy volunteers.

12.6 QT/QTc Prolongation

In a thorough QT study in healthy men and women aged 50 years and older, no QTc prolonging effects were observed for XARELTO (15 mg and 45 mg, single-dose).

13 NON-CLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, and Impairment of Fertility

Rivaroxaban was not carcinogenic when administered by oral gavage to mice or rats for up to 2 years. The systemic exposures (AUCs) of unbound rivaroxaban in male and female mice at the highest dose tested (60 mg/kg/day) were 1- and 2-times, respectively, the human exposure of unbound drug at the human dose of 20 mg/day. Systemic exposures of unbound drug in male and female rats at the highest dose tested (60 mg/kg/day) were 2- and 4-times, respectively, the human exposure.

Rivaroxaban was not mutagenic in bacteria (Ames-Test) or clastogenic in V79 Chinese hamster lung cells *in vitro* or in the mouse micronucleus test *in vivo*.

No impairment of fertility was observed in male or female rats when given up to 200 mg/kg/day of rivaroxaban orally. This dose resulted in exposure levels, based on the unbound AUC, at least 13 times the exposure in humans given 20 mg rivaroxaban daily.

14 CLINICAL STUDIES

14.1 Stroke Prevention in Nonvalvular Atrial Fibrillation

The evidence for the efficacy and safety of XARELTO was derived from ROCKET AF, a multi-national, double-blind study comparing XARELTO (at a dose of 20 mg once daily with the evening meal in patients with CrCl >50 mL/min and 15 mg once daily with the evening meal in patients with CrCl 30 to <50 mL/min) to warfarin (titrated to INR 2.0 to 3.0) to reduce the risk of stroke and non-central nervous system (CNS) systemic embolism in patients with nonvalvular atrial fibrillation (AF). Patients had to have one or more of the following additional risk factors for stroke:

- a prior stroke (ischemic or unknown type), transient ischemic attack (TIA) or non-CNS systemic embolism, or
- 2 or more of the following risk factors:
 - age ≥75 years,
 - hypertension,
 - heart failure or left ventricular ejection fraction ≤35%, or
 - diabetes mellitus

ROCKET AF was a non-inferiority study designed to demonstrate that XARELTO preserved more than 50% of warfarin's effect on stroke and non-CNS systemic embolism as established by previous placebo-controlled studies of warfarin in atrial fibrillation.

A total of 14264 patients were randomized and followed on study treatment for a median of 590 days. The mean age was 71 years and the mean CHADS₂ score was 3.5. The population was 60% male, 83% Caucasian, 13% Asian and 1.3% Black. There was a history of stroke, TIA, or non-CNS systemic embolism in 55% of patients, and 38% of patients had not taken a vitamin K antagonist (VKA)

XARELTO® (rivaroxaban) tablets

within 6 weeks at time of screening. Concomitant diseases of patients in this study included hypertension 91%, diabetes 40%, congestive heart failure 63%, and prior myocardial infarction 17%. At baseline, 37% of patients were on aspirin (almost exclusively at a dose of 100 mg or less) and few patients were on clopidogrel. Patients were enrolled in Eastern Europe (39%); North America (19%); Asia, Australia, and New Zealand (15%); Western Europe (15%); and Latin America (13%). Patients randomized to warfarin had a mean percentage of time in the INR target range of 2.0 to 3.0 of 55%, lower during the first few months of the study.

In ROCKET AF, XARELTO was demonstrated non-inferior to warfarin for the primary composite endpoint of time to first occurrence of stroke (any type) or non-CNS systemic embolism [HR (95% CI): 0.88 (0.74, 1.03)], but superiority to warfarin was not demonstrated. There is insufficient experience to determine how XARELTO and warfarin compare when warfarin therapy is well-controlled.

Table 6 displays the overall results for the primary composite endpoint and its components.

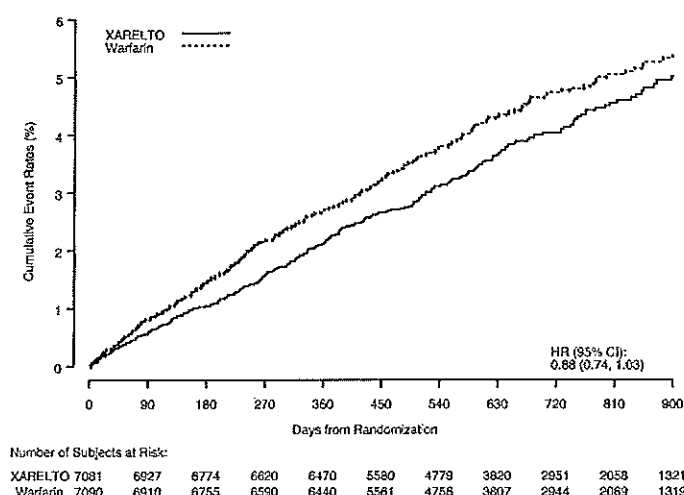
Table 6: Primary Composite Endpoint Results in ROCKET AF Study

Event	XARELTO		Warfarin		XARELTO vs. Warfarin Hazard Ratio (95% CI)
	N = 7081 n (%)	Event Rate (per 100 Pt-yrs)	N = 7090 n (%)	Event Rate (per 100 Pt-yrs)	
Primary Composite Endpoint*	269 (3.8)	2.1	306 (4.3)	2.4	0.88 (0.74, 1.03)
Stroke	253 (3.6)	2.0	281 (4.0)	2.2	
Hemorrhagic Stroke	33 (0.5)	0.3	57 (0.8)	0.4	
Ischemic Stroke	206 (2.9)	1.6	208 (2.9)	1.6	
Unknown Stroke Type	19 (0.3)	0.2	18 (0.3)	0.1	
Non-CNS Systemic Embolism	20 (0.3)	0.2	27 (0.4)	0.2	

*The primary endpoint was the time to first occurrence of stroke (any type) or non-CNS systemic embolism. Data are shown for all randomized patients followed to site notification that the study would end.

Figure 1 is a plot of the time from randomization to the occurrence of the first primary endpoint event in the two treatment arms.

Figure 1: Time to First Occurrence of Stroke (any type) or Non-CNS Systemic Embolism by Treatment Group



The efficacy of XARELTO was generally consistent across major subgroups.

The protocol for ROCKET AF did not stipulate anticoagulation after study drug discontinuation, but warfarin patients who completed the study were generally maintained on warfarin. XARELTO patients were generally switched to warfarin without a period of co-administration of warfarin and XARELTO, so that they were not adequately anticoagulated after stopping XARELTO until attaining a therapeutic INR. During the 28 days following the end of the study, there were 22 strokes in the 4637 patients taking XARELTO vs. 6 in the 4691 patients taking warfarin.

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Few patients in ROCKET AF underwent electrical cardioversion for atrial fibrillation. The utility of XARELTO for preventing post-cardioversion stroke and systemic embolism is unknown.

14.2 Prophylaxis of Deep Vein Thrombosis

XARELTO was studied in 9011 patients (4487 XARELTO-treated, 4524 enoxaparin-treated patients) in the RECORD 1, 2, and 3 studies.

The two randomized, double-blind, clinical studies (RECORD 1 and 2) in patients undergoing elective total hip replacement surgery compared XARELTO 10 mg once daily starting at least 6 to 8 hours (about 90% of patients dosed 6 to 10 hours) after wound closure versus enoxaparin 40 mg once daily started 12 hours preoperatively. In RECORD 1 and 2, a total of 6727 patients were randomized and 6579 received study drug. The mean age (\pm standard deviation (SD)) was 63 ± 12.2 (range 18 to 93) years with 49% of patients ≥ 65 years and 55% of patients were female. More than 82% of patients were White, 7% were Asian, and less than 2% were Black. The studies excluded patients undergoing staged bilateral total hip replacement, patients with severe renal impairment defined as an estimated creatinine clearance <30 mL/min, or patients with significant liver disease (hepatitis or cirrhosis). In RECORD 1, the mean exposure duration (\pm SD) to active XARELTO and enoxaparin was 33.3 ± 7.0 and 33.6 ± 8.3 days, respectively. In RECORD 2, the mean exposure duration to active XARELTO and enoxaparin was 33.5 ± 6.9 and 12.4 ± 2.9 days, respectively. After Day 13, oral placebo was continued in the enoxaparin group for the remainder of the double-blind study duration. The efficacy data for RECORD 1 and 2 are provided in Table 7.

Table 7: Summary of Key Efficacy Analysis Results for Patients Undergoing Total Hip Replacement Surgery - Modified Intent-to-Treat Population

Treatment Dosage and Duration	RECORD 1			RECORD 2		
	XARELTO 10 mg once daily	Enoxaparin 40 mg once daily	RRR*, p-value	XARELTO 10 mg once daily	Enoxaparin 40 mg once daily	RRR*, p-value
Number of Patients	N = 1513	N = 1473		N = 834	N = 835	
Total VTE	17 (1.1%)	57 (3.9%)	71% (95% CI: 50, 83), p<0.001	17 (2.0%)	70 (8.4%)	76% (95% CI: 59, 88), p<0.001
Components of Total VTE						
Proximal DVT	1 (0.1%)	31 (2.1%)		5 (0.6%)	40 (4.8%)	
Distal DVT	12 (0.8%)	26 (1.8%)		11 (1.3%)	43 (5.2%)	
Non-fatal PE	3 (0.2%)	1 (0.1%)		1 (0.1%)	4 (0.5%)	
Death (any cause)	4 (0.3%)	4 (0.3%)		2 (0.2%)	4 (0.5%)	
Number of Patients	N = 1600	N = 1587		N = 928	N = 929	
Major VTE†	3 (0.2%)	33 (2.1%)	91% (95% CI: 71, 97), p<0.001	6 (0.7%)	45 (4.8%)	87% (95% CI: 69, 94), p<0.001
Number of Patients	N = 2103	N = 2119		N = 1178	N = 1179	
Symptomatic VTE	5 (0.2%)	11 (0.5%)		3 (0.3%)	15 (1.3%)	

* Relative Risk Reduction; CI=confidence interval

† Includes the placebo-controlled period of RECORD 2

‡ Proximal DVT, nonfatal PE or VTE-related death

One randomized, double-blind, clinical study (RECORD 3) in patients undergoing elective total knee replacement surgery compared XARELTO 10 mg once daily started at least 6 to 8 hours (about 90% of patients dosed 6 to 10 hours) after wound closure versus enoxaparin. In RECORD 3, the enoxaparin regimen was 40 mg once daily started 12 hours preoperatively. The mean age (\pm SD) of patients in the study was 68 ± 9.0 (range 28 to 91) years with 68% of patients ≥ 65 years. Sixty-eight percent (68%) of patients were female. Eighty-one percent (81%) of patients were White, less than 7% were Asian, and less than 2% were Black. The study excluded patients with severe renal impairment defined as an estimated creatinine clearance <30 mL/min or patients with significant liver disease (hepatitis or cirrhosis). The mean exposure duration (\pm SD) to active XARELTO and enoxaparin was 11.9 ± 2.3 and 12.5 ± 3.0 days, respectively. The efficacy data are provided in Table 8.

XARELTO® (rivaroxaban) tablets**Table 8: Summary of Key Efficacy Analysis Results for Patients Undergoing Total Knee Replacement Surgery - Modified Intent-to-Treat Population**

Treatment Dosage and Duration	RECORD 3		
	XARELTO 10 mg once daily	Enoxaparin 40 mg once daily	RRR*, p-value
Number of Patients	N = 813	N = 871	
Total VTE	79 (9.7%)	164 (18.8%)	48% (95% CI: 34, 60), p<0.001
Components of events contributing to Total VTE			
Proximal DVT	9 (1.1%)	19 (2.2%)	
Distal DVT	74 (9.1%)	154 (17.7%)	
Non-fatal PE	0	4 (0.5%)	
Death (any cause)	0	2 (0.2%)	
Number of Patients	N = 895	N = 917	
Major VTE†	9 (1.0%)	23 (2.5%)	60% (95% CI: 14, 81), p=0.024
Number of Patients	N = 1206	N = 1226	
Symptomatic VTE	8 (0.7%)	24 (2.0%)	

* Relative Risk Reduction; CI=confidence interval

† Proximal DVT, nonfatal PE or VTE-related death

16 HOW SUPPLIED/STORAGE AND HANDLING

XARELTO (rivaroxaban) Tablets are available in the strengths and packages listed below:

- 10 mg tablets are round, light red, biconvex film-coated tablets marked with a triangle pointing down above a "10" on one side, and an "Xa" on the other side. The tablets are supplied in the packages listed:

NDC 50458-580-30 Bottle containing 30 tablets

NDC 50458-580-10 Blister package containing 100 tablets (10 blister cards containing 10 tablets each)

- 15 mg tablets are round, red, biconvex film-coated tablets with a triangle pointing down above a "15" marked on one side and "Xa" on the other side. The tablets are supplied in the packages listed:

NDC 50458-578-30 Bottle containing 30 tablets

NDC 50458-578-90 Bottle containing 90 tablets

NDC 50458-578-10 Blister package containing 100 tablets (10 blister cards containing 10 tablets each)

- 20 mg tablets are triangle-shaped, dark red film-coated tablets with a triangle pointing down above a "20" marked on one side and "Xa" on the other side. The tablets are supplied in the packages listed:

NDC 50458-579-30 Bottle containing 30 tablets

NDC 50458-579-90 Bottle containing 90 tablets

NDC 50458-579-10 Blister package containing 100 tablets (10 blister cards containing 10 tablets each)

Store at 25° C (77° F) or room temperature; excursions permitted to 15°-30° C (59°-86° F) [see USP Controlled Room Temperature].

Keep out of the reach of children.

17 PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Medication Guide).

17.1 Instructions for Patient Use

- Advise patients to take XARELTO only as directed.
- Remind patients to not discontinue XARELTO without first talking to their healthcare professional.
- Advise patients with atrial fibrillation to take XARELTO once daily with the evening meal.
- If a dose is missed, advise the patient to take XARELTO as soon as possible on the same day and continue on the following day with their recommended daily dose regimen.

XARELTO® (rivaroxaban) tablets**17.2 Bleeding Risks**

- Advise patients to report any unusual bleeding or bruising to their physician. Inform patients that it might take them longer than usual to stop bleeding, and that they may bruise and/or bleed more easily when they are treated with XARELTO [see Warnings and Precautions (5.2)].
- If patients have had neuraxial anesthesia or spinal puncture, and particularly, if they are taking concomitant NSAIDs or platelet inhibitors, advise patients to watch for signs and symptoms of spinal or epidural hematoma, such as tingling, numbness (especially in the lower limbs) and muscular weakness. If any of these symptoms occur, advise the patient to contact his or her physician immediately [see Boxed Warning].

17.3 Invasive or Surgical Procedures

Instruct patients to inform their health care professional that they are taking XARELTO before any invasive procedure (including dental procedures) is scheduled.

17.4 Concomitant Medication and Herbs

Advise patients to inform their physicians and dentists if they are taking, or plan to take, any prescription or over-the-counter drugs or herbs, so their healthcare professionals can evaluate potential interactions [see Drug Interactions (7)].

17.5 Pregnancy and Pregnancy-Related Hemorrhage

- Advise patients to inform their physician immediately if they become pregnant or intend to become pregnant during treatment with XARELTO [see Use in Specific Populations (8.1)].
- Advise pregnant women receiving XARELTO to immediately report to their physician any bleeding or symptoms of blood loss [see Warnings and Precautions (5.4)].

17.6 Nursing

Advise patients to discuss with their physician if they are nursing or intend to nurse during anticoagulant treatment [see Use in Specific Populations (8.3)].

17.7 Females of Reproductive Potential

Advise patients who can become pregnant to discuss pregnancy planning with their physician [see Use in Specific Populations (8.6)].

Active Ingredient Made in Germany

Finished Product Manufactured by:
Janssen Ortho, LLC
Gurabo, PR 00778

Manufactured for:
Janssen Pharmaceuticals, Inc.
Titusville, NJ 08560

Licensed from:
Bayer HealthCare AG
51368 Leverkusen, Germany

Janssen 

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MEDICATION GUIDE

XARELTO® (zah-REL-toe)
(rivaroxaban)**Tablets**

Read this Medication Guide before you start taking XARELTO and each time you get a refill. There may be new information. This Medication Guide does not take the place of talking with your doctor about your medical condition or your treatment.

What is the most important information I should know about XARELTO?**• For people taking XARELTO for atrial fibrillation:**

People with atrial fibrillation (an irregular heart beat) are at an increased risk of forming a blood clot in the heart, which can travel to the brain, causing a stroke, or to other parts of the body. XARELTO lowers your chance of having a stroke by helping to prevent clots from forming. If you stop taking XARELTO, you may have increased risk of forming a clot in your blood.

Do not stop taking XARELTO without talking to the doctor who prescribes it for you. Stopping XARELTO increases your risk of having a stroke.

If you have to stop taking XARELTO, your doctor may prescribe another blood thinner medicine to prevent a blood clot from forming.

- XARELTO can cause bleeding which can be serious, and rarely may lead to death. This is because XARELTO is a blood thinner medicine that reduces blood clotting. While you take XARELTO you are likely to bruise more easily and it may take longer for bleeding to stop.

You may have a higher risk of bleeding if you take XARELTO and take other medicines that increase your risk of bleeding, including:

- aspirin or aspirin containing products
- non-steroidal anti-inflammatory drugs (NSAIDs)
- warfarin sodium (Coumadin®, Jantoven®)
- any medicine that contains heparin
- clopidogrel (Plavix®)
- prasugrel (Effient®)
- ticagrelor (Brilinta®)

Tell your doctor if you take any of these medicines. Ask your doctor or pharmacist if you are not sure if your medicine is one listed above.

Call your doctor or get medical help right away if you develop any of these signs or symptoms of bleeding:

- unexpected bleeding or bleeding that lasts a long time, such as:
 - nose bleeds that happen often
 - unusual bleeding from the gums
 - menstrual bleeding that is heavier than normal or vaginal bleeding
- bleeding that is severe or you cannot control
- red, pink or brown urine
- bright red or black stools (looks like tar)
- cough up blood or blood clots
- vomit blood or your vomit looks like "coffee grounds"
- headaches, feeling dizzy or weak
- pain, swelling, or new drainage at wound sites

See "What are the possible side effects of XARELTO?" for more information about side effects.

What is XARELTO?

- XARELTO is a prescription medicine used to:
 - reduce the risk of stroke and blood clots in people who have a medical condition called atrial fibrillation. With atrial fibrillation, part of the heart does not beat the way it should. This can lead to the formation of blood clots, which can travel to the brain, causing a stroke, or to other parts of the body.
 - reduce the risk of forming a blood clot in the legs and lungs of people who have just had hip or knee replacement surgery.

It is not known if XARELTO is safe and works in children.

Who should not take XARELTO?**Do not take XARELTO if you:**

- currently have certain types of abnormal bleeding. Talk to your doctor before taking XARELTO if you currently have unusual bleeding.
- are allergic to rivaroxaban or any of the ingredients in XARELTO. See the end of this leaflet for a complete list of ingredients in XARELTO.

What should I tell my doctor before taking XARELTO?

Before you take XARELTO, tell your doctor if you:

- have ever had bleeding problems
- have liver or kidney problems
- have any other medical condition
- are pregnant or planning to become pregnant. It is not known if XARELTO will harm your unborn baby.
- are breastfeeding or plan to breastfeed. It is not known if XARELTO passes into your breast milk. You and your doctor should decide if you will take XARELTO or breastfeed.

Tell all of your doctors and dentists that you are taking XARELTO. They should talk to the doctor who prescribed XARELTO for you before you have any surgery, medical or dental procedure.

Tell your doctor about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal supplements. Some of your other medicines may affect the way XARELTO works. Certain medicines may increase your risk of bleeding. See "What is the most important information I should know about XARELTO?"

Especially tell your doctor if you take:

- ketoconazole (Nizoral®)
- itraconazole (Onmel™, Sporanox®)
- ritonavir (Norvir®)
- lopinavir/ritonavir (Kaletra®)
- indinavir (Crixivan®)
- carbamazepine (Carbatrol®, Equetro®, Tegretol®, Tegretol®-XR, Teril™, Epitol®)
- phenytoin (Dilantin-125®, Dilantin®)
- phenobarbital (Solfoton™)
- rifampin (Rifater®, Rifamate®, Rimactane®, Rifadin®)
- St. John's wort (Hypericum perforatum)

Ask your doctor if you are not sure if your medicine is one listed above.

Know the medicines you take. Keep a list of them to show your doctor and pharmacist when you get a new medicine.

How should I take XARELTO?

- Take XARELTO exactly as prescribed by your doctor. Do not change your dose or stop taking XARELTO unless your doctor tells you to.
- For people who have:
 - **atrial fibrillation:** Take XARELTO 1 time a day with your evening meal. Stopping XARELTO may increase your risk of having a stroke or forming blood clots in other parts of your body.
 - **hip or knee replacement surgery:** Take XARELTO 1 time a day with or without food.
- Your doctor will decide how long you should take XARELTO. Do not stop taking XARELTO without talking with your doctor first.
- Your doctor may stop XARELTO for a short time before any surgery, medical or dental procedure. Your doctor will tell you when to start taking XARELTO again after your surgery or procedure.
- Do not run out of XARELTO. Refill your prescription of XARELTO before you run out. When leaving the hospital following a hip or knee replacement, be sure that you will have XARELTO available to avoid missing any doses.
- If you miss a dose of XARELTO, take it as soon as you remember on the same day.
- If you take too much XARELTO, go to the nearest hospital emergency room or call your doctor right away.

What are the possible side effects of XARELTO?

- See "What is the most important information I should know about XARELTO?"

Tell your doctor if you have any side effect that bothers you or that does not go away.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store XARELTO?

- Store XARELTO at room temperature between 59° to 86°F (15° to 30° C).

Keep XARELTO and all medicines out of the reach of children.

General information about XARELTO.

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use XARELTO for a condition for which it was not prescribed. Do not give XARELTO to other people, even if they have the same condition. It may harm them.

This Medication Guide summarizes the most important information about XARELTO. If you would like more information, talk with your doctor. You can ask your pharmacist or doctor for information about XARELTO that is written for health professionals.

For more information call 1-800-526-7736 or go to www.XARELTO-US.com.

What are the ingredients in XARELTO?

Active ingredient: rivaroxaban

Inactive ingredients: croscarmellose sodium, hypromellose, lactose monohydrate, magnesium stearate, microcrystalline cellulose, and sodium lauryl sulfate.

The proprietary film coating mixture for XARELTO 10 mg tablets is Opadry® Pink contains: ferric oxide red, hypromellose, polyethylene glycol 3350, and titanium dioxide.

The proprietary film coating mixture for XARELTO 15 mg tablets is Opadry® Red, contains: ferric oxide red, hypromellose, polyethylene glycol 3350, and titanium dioxide.

The proprietary film coating mixture for XARELTO 20 mg tablets is Opadry® II Dark Red, contains: ferric oxide red, polyethylene glycol 3350, polyvinyl alcohol (partially hydrolyzed), talc, and titanium dioxide.

Revised: December 2011

This Medication Guide has been approved by the U.S. Food and Drug Administration.

Finished Product Manufactured by:
Janssen Ortho, LLC
Gurabo, PR 00778

Manufactured for:
Janssen Pharmaceuticals, Inc.
Titusville, NJ 08560

Licensed from:
Bayer HealthCare AG
51368 Leverkusen, Germany



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